

		FOR OHF USE					

LL 1

**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0039966</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>BALMORAL HOME</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>11/01/99</u> to <u>10/31/00</u> and certify to the best of my knowledge and belief that the said content are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge	
<b>Address:</b> <u>2055 WEST BALMORAL</u> <u>CHICAGO</u> <u>60625</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment	
<b>County:</b> <u>COOK</u>		(Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>( 773 ) 561-8661</u> <b>Fax #</b> <u>( 773 ) 561-9376</u>		(Type or Print Name) _____	
<b>IDPA ID Number:</b> <u>363902876001</u>		(Title) _____	
<b>Date of Initial License for Current Owners:</b> <u>09/10/93</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		(Print Name and Title) <u>Sanford Alper - Principal</u>	
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		(Firm Name & Address) <u>Kessler, Orlean, Silver &amp; Company, P.C.</u> <u>7400 North Oak Park Avenue, Niles, Illinois 60714</u> (Telephone) <u>(847) 647-6600</u> <b>Fax #</b> <u>(847) 647-7554</u>	
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Sanford Alper</u> <b>Telephone Number:</b> <u>(847) 647-6600</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone #</b> (217) 782-1630	

## STATE OF ILLINOIS

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Facility Name & ID Number BALMORAL HOME# 0039966 Report Period Beginning: 11/01/99 Ending: 10/31/00

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/AD. How many bed-hold days during this year were paid by Public Aid?  
1,522 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☒ NO ☐H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☐ NO ☒I. On what date did you start providing long term care at this location?  
Date started 09/10/1993J. Was the facility purchased or leased after January 1, 1978?  
YES ☐ Date \_\_\_\_\_ NO ☒K. Was the facility certified for Medicare during the reporting year?  
YES ☒ NO ☐ If YES, enter number  
of beds certified 34 and days of care provided 852Medicare Intermediary Mutual Omaha

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 10/31/2000 Fiscal Year: 10/31/2000  
\* All facilities other than governmental must report on the accrual basis.

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>213</u>	Skilled (SNF)	<u>213</u>	<u>77,958</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>213</u>	TOTALS	<u>213</u>	<u>77,958</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>68,488</u>	<u>4,270</u>	<u>1,094</u>	<u>73,852</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>68,488</u>	<u>4,270</u>	<u>1,094</u>	<u>73,852</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 94.73%

## STATE OF ILLINOIS

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Facility Name & ID Number **BALMORAL HOME** # **0039966** Report Period Beginning: **11/01/99** Ending: **10/31/00**  
**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	205,200	62,169	6,710	274,079		274,079		274,079			1
2	Food Purchase		227,572		227,572	(32,120)	195,452		195,452			2
3	Housekeeping	110,925	20,790	12,492	144,207		144,207		144,207			3
4	Laundry	56,447	20,807		77,254		77,254		77,254			4
5	Heat and Other Utilities			113,887	113,887		113,887		113,887			5
6	Maintenance	58,374		18,396	76,770		76,770	(1,255)	75,515			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	430,946	331,338	151,485	913,769	(32,120)	881,649	(1,255)	880,394			8
	<b>B. Health Care and Programs</b>											
9	Medical Director											9
10	Nursing and Medical Records	1,112,061	54,784	3,032	1,169,877		1,169,877		1,169,877			10
10a	Therapy	34,467		20,753	55,220		55,220		55,220			10a
11	Activities	69,048	1,054		70,102		70,102		70,102			11
12	Social Services	42,138		5,523	47,661		47,661		47,661			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*			20,499	20,499		20,499		20,499			15
16	<b>TOTAL Health Care and Programs</b>	1,257,714	55,838	49,807	1,363,359		1,363,359		1,363,359			16
	<b>C. General Administration</b>											
17	Administrative	173,145			173,145		173,145		173,145			17
18	Directors Fees											18
19	Professional Services			80,498	80,498		80,498	(1,782)	78,716			19
20	Dues, Fees, Subscriptions & Promotions			28,567	28,567		28,567	(857)	27,710			20
21	Clerical & General Office Expenses	184,037	7,946	11,440	203,423		203,423	2,438	205,861			21
22	Employee Benefits & Payroll Taxes			205,189	205,189	32,120	237,309	13,775	251,084			22
23	Inservice Training & Education											23
24	Travel and Seminar			2,370	2,370		2,370		2,370			24
25	Other Admin. Staff Transportation			5,556	5,556		5,556		5,556			25
26	Insurance-Prop.Liab.Malpractice			48,204	48,204		48,204		48,204			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	357,182	7,946	381,824	746,952	32,120	779,072	13,574	792,646			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	2,045,842	395,122	583,116	3,024,080		3,024,080	12,319	3,036,399			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

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Facility Name & ID Number **BALMORAL HOME**

#0039966

Report Period Beginning:

11/01/99

Ending:

10/31/00

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			44,718	44,718		44,718	(12,785)	31,933			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,500	2,500		2,500	(2,500)				32
33	Real Estate Taxes			284,196	284,196		284,196		284,196			33
34	Rent-Facility & Grounds			1,243,920	1,243,920		1,243,920	(1,243,920)				34
35	Rent-Equipment & Vehicles			2,650	2,650		2,650		2,650			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			1,577,984	1,577,984		1,577,984	(1,259,205)	318,779			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			40	40		40	(40)				39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			117,254	117,254		117,254		117,254			42
43	Other (specify):* <b>Non Allowable Exp</b>			3,691	3,691		3,691	(3,691)				43
44	<b>TOTAL Special Cost Centers</b>			120,985	120,985		120,985	(3,731)	117,254			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	2,045,842	395,122	2,282,085	4,723,049		4,723,049	(1,250,617)	3,472,432			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**VI. ADJUSTMENT DETAIL**      A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.  
 In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1	2	3	
	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,785)	30		9
10	Interest and Other Investment Income	(2,500)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(202)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(50)	21		18
19	Entertainment				19
20	Contributions	(100)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal				26
27	Property Replacement Tax	(3,000)	43		27
28	Nurse Aide Training for Non-Employees				28
29	Yellow Page Advertising	(857)	20		29
30	Other-Attach Schedule				30
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	\$ (19,494)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1	2	
		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,227,646)		34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	\$ (1,227,646)		36
	(sum of SUBTOTALS			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	\$ (1,247,140)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1	2	3	4	
		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			\$		47

ID# 0039966  
Report Period Beginning: 11/01/99  
Ending: 10/31/00

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line
1	Reference		1
1	Franchise Tax	\$ (50)	43
2	Trust Fee	(75)	43
3	Deferred Maintenance	(1,255)	6
4	Collection Fees	(1,782)	19
5	Political Contributions	(275)	43
6	Radiology	(40)	39
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
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21			21
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73			73
74			74
75			75
76			76
77			77
78			78
79			79
80			80
81			81
82			82
83			83
84			84
85			85
86			86
87			87
88			88
89			89
90	Total	(3,477)	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number BALMORAL HOME

# 0039966

Report Period Beginning:

11/01/99

Ending:

10/31/00

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(1,255)	0	0	0	0	0	0	0	0	0	0	(1,255)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,255)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,255)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,782)	0	0	0	0	0	0	0	0	0	0	(1,782)	19
20	Fees, Subscriptions & Promotions	(857)	0	0	0	0	0	0	0	0	0	0	(857)	20
21	Clerical & General Office Expenses	(50)	2,488	0	0	0	0	0	0	0	0	0	2,438	21
22	Employee Benefits & Payroll Taxes	0	13,775	0	0	0	0	0	0	0	0	0	13,775	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(2,689)</b>	<b>16,263</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>13,574</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(3,944)</b>	<b>16,263</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>12,319</b>	<b>29</b>

## Summary B

#	0039966	Report Period Beginning:	11/01/99	Ending:	10/31/00
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**SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I**

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Marvin Mermelstein	50.00%	Winston Manor Nursing Home	Chicago, IL	Nivram Mngt, Inc	Chicago, IL	Management
Joseph Mermelstein	50.00%	Emerald Park Nursing Home	Evergreen Park, IL			
		Central Nursing Home, Inc.	Chicago, IL			
		Sovereign Healthcare, LLC.	Chicago, IL			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$	Nivram Management, Inc.		\$	\$	1
2	V	21 Office Expenses		Nivram Management, Inc.	50.00%	82	82	2
3	V	21 Supplies		Nivram Management, Inc.	50.00%	1,757	1,757	3
4	V	43 Franchise Tax		Nivram Management, Inc.	50.00%	11	11	4
5	V	22 Payroll Taxes		Nivram Management, Inc.	50.00%	13,775	13,775	5
6	V	21 Telephone		Nivram Management, Inc.	50.00%	638	638	6
7	V	21 Bank Charges		Nivram Management, Inc.	50.00%	11	11	7
8	V	34 Rent	1,243,920	Louise Mermelstein	0.00%		(1,243,920)	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,243,920			\$ 16,274	\$ * (1,227,646)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BALMORAL HOME # 0039966 Report Period Beginning: 11/01/99 Ending: 10/31/00

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	HENRY MERMELSTEIN	Administrative Asst.	Administrative	0.00%	180,000	8	10.00%	Salary	\$ 20,000	L17, Col 1	1
2	LOUISE MERMELSTEIN	Dietary Supervisor	Support	0.00%	50,250	26	33.00%	Salary	24,750	L1, Col 1	2
3	MARVIN MERMELSTEIN	Plant Supervisor	Support	50.00%	38,640	4	20.00%	Salary	9,660	L6, Col 1	3
4	DOREEN MERMELSTEIN	Administrative Asst.	Clerical	0.00%	69,309	14	23.00%	Salary	20,251	L21, Col 1	4
5											5
6	MARVIN MERMELSTEIN	Administrative Asst.	Administrative	See Above	145,360	13	20.00%	Salary	36,340	L17, Col 1	6
7	JOSEPH MERMELSTEIN	Owner	Administrative	0.00%	53,291	4	N/A	Salary	26,709	L21, Col 1	7
8											8
9											9
10					See Attached Schedule B						10
11											11
12											12
13								TOTAL	\$ 137,710		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees)  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

## STATE OF ILLINOIS

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Facility Name & ID Number BALMORAL HOME# 0039966 Report Period Beginning: 11/01/99 Ending: 10/31/00

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Nivram Management, Inc  
 Street Address 2155 W. Pierce  
 City / State / Zip Code Chicago, IL 60622  
 Phone Number ( 773) 252-3208  
 Fax Number ( 773) 252-3688

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Bank Charges	Resident Beds	942	5	\$ 50	\$	213	\$ 11	1
2	21	Office Expenses	Resident Beds	942	5	361		213	82	2
3	21	Supplies	Resident Beds	942	5	7,772		213	1,757	3
4	49	Franchise Tax	Resident Beds	942	5	50		213	11	4
5	22	Payroll Taxes	Resident Beds	942	5	60,925		213	13,775	5
6	21	Telephone	Resident Beds	942	5	2823		213	638	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 71,981	\$		\$ 16,274	25

Facility Name & ID Number **BALMORAL HOME**# **0039966**

Report Period Beginning:

**11/01/99**

Ending:

**10/31/00****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE****A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1							\$					\$	1
2													2
3													3
4													4
5													5
	Working Capital												
6													6
7													7
8													8
9	TOTAL Facility Related						\$					\$	9
	B. Non-Facility Related*												
10													10
11													11
12													12
13													13
14	TOTAL Non-Facility Related						\$					\$	14
15	TOTALS (line 9+line14)						\$					\$	15

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

1. Real Estate Tax accrual used on 1999 report.	\$	214,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	248,197	2
3. Under or (over) accrual (line 2 minus line 1).	\$	34,197	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$	250,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	\$	284,197	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1995	237,714	8
1996	246,948	9
1997	248,480	10
1998	249,874	11
1999	247,197	12

1999 Tax Bill = 248,197			
Estimated Increase 1.03%			
Estimated 200 Tax = 255,643			
Rounded = 250,000			

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

- NOTES:
1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
This denial must be no more than four years old at the time the cost report is filed.

Facility Name &amp; ID Number BALMORAL HOME

# 0039966

Report Period Beginning:

11/01/99

Ending:

10/31/00

**X. BUILDING AND GENERAL INFORMATION:**

A. Square Feet: 54,360 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 3

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_

3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

**XI. OWNERSHIP COSTS:**

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	33,375	1993	\$ 90,430	1
2					2
3	TOTALS	33,375		\$ 90,430	3

Facility Name & ID Number **BALMORAL HOME**# **0039966**

Report Period Beginning:

11/01/99

Ending:

10/31/00

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	213		1993	1968	\$ 985,048	\$	30	\$	\$	\$ 985,048	4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Leasehold Improvement			1994	8,500	218	35	243	25	1,579	9
10	Fence			1994	2,700	69	35	77	8	424	10
11	Leasehold Improvement			1995	4,813	123	10	481	358	2,646	11
12	Leasehold Improvement			1995	3,750		10	375	375	2,062	12
13	Fire Alarm			1996	8,750	224	15	584	360	2,628	13
14	Laundry Chute			1996	2,181	56	15	146	90	657	14
15	Concrete Ramp			1996	2,500	64	35	72	8	324	15
16	Phone System			1993	4,475		5			4,475	16
17	Time Clock System			1993	1,853	26	5		(26)	1,853	17
18	Carpet			1993	1,144	16	5		(16)	1,144	18
19	Phone System			1994	2,967	264	5		(264)	2,967	19
20	Hot Water Heater			1995	3,035	271	5	304	33	3,035	20
21	Awnings and Signs			1997	5,923	152	39	152		532	21
22	Parking Lot			1997	6,600	669	15	440	(229)	1,540	22
23	Remodel Laundry Area			1997	5,399	138	7	772	634	2,702	23
24	Remodel Laundry Area			1997	19,779	507	7	2,826	2,319	3,591	24
25	Handrails			1997	5,750	147	7	822	675	2,877	25
26	Fire Alarm			1997	16,726	428	7	2,390	1,962	8,365	26
27	Light Fixtures			1997	6,552	669	7	936	267	3,276	27
28	Boiler			1997	925	24	7	132	108	462	28
29	Kitchen Improvements			1997	2,875	74	7	410	336	1,435	29
30	Elevator			1997	2,300	59	7	328	269	1,148	30
31	Bathroom Remodeling			1997	312	8	7	44	36	154	31
32	HVAC, Boiler			1998	14,915	382	7	2,131	1,749	5,327	32
33	Ward Doors			1998	2,803	72	35	80	8	200	33
34	Concrete Steps			1998	2,500	64	35	71	7	178	34
35	Fire Alarm			1999	16,000	410	10	1,600	1,190	2,400	35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 1,141,075	\$ 5,134		\$ 15,416	\$ 10,282	\$ 1,043,029	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					\$	\$		\$	\$		4
5											5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Boiler and Ductowrk		1999		18,500	474	10	1,850	1,376	2,775	9
10	Windows		1999		1,498	38	10	150	112	225	10
11	Cooling Tower		2000		8,860	123	10	443	320	443	11
12	Heater		2000		3,000	3	10	150	147	150	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 31,858	\$ 638		\$ 2,593	\$ 1,955	\$ 3,593	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## STATE OF ILLINOIS

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Facility Name & ID Number **BALMORAL HOME**# **0039966**

Report Period Beginning:

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## XI. OWNERSHIP COSTS (continued)

## C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 111,800	\$ 38,139	\$ 9,465	\$ (28,674)	5-10 Yrs	\$ 35,465	37
38	Current Year Purchases	700		35	35	5-10 Yrs	70	38
39	Fully Depreciated Assets	41,229	807	4,424	3,617	5 Yrs	41,229	39
40								40
41	TOTALS	\$ 153,729	\$ 38,946	\$ 13,924	\$ (25,022)		\$ 76,764	41

## D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

## E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 1,417,092	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 44,718	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 31,933	49 **
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$ (12,785)	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 1,123,386	51

## F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

## G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
- If NO, see instructions.
- ☒ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6	Allocation from Management Company							6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
- This amount was calculated by dividing the total amount to be amortized by the length of the lease.

9. Option to Buy:
- ☐ YES ☒ NO
- Terms:

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 1,743
- Description: Icemaker

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Faculy Vehicle	1999 Chevy Tahoe	\$ 462.98	\$ 5,556	17
18					18
19					19
20					20
21	TOTAL		\$ 462.98	\$ 5,556	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	\$
13.	/2002	\$
14.	/2003	\$

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number **BALMORAL HOME** # **0039966** Report Period Beginning: **11/01/99** Ending: **10/31/00**

**XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$	\$	\$		\$	
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$		\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number **BALMORAL HOME**# **0039966**

Report Period Beginning:

11/01/99

Ending:

10/31/00

## XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	L10A, Col 1, 3	4 hrs	\$ 273		\$		4	\$ 273	1
2	Licensed Speech and Language Development Therapist	L10A, Col 3	hrs		78	6,337		78	6,337	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, Col 3	hrs		37	1,515		37	1,515	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L10, Col 2	# of prescrpts				20,459		20,459	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Attached Sch A					11,383	16,474		27,857	13
14	TOTAL			\$ 273	115	\$ 19,235	\$ 36,933	119	\$ 56,441	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (46,843)	\$ (46,843)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance )	421,116	421,116	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	548,749	548,749	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 923,022	\$ 923,022	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		90,430	13
14	Buildings, at Historical Cost		985,048	14
15	Leasehold Improvements, at Historical Cos	170,660	170,660	15
16	Equipment, at Historical Cost	170,954	170,954	16
17	Accumulated Depreciation (book methods)	(162,513)	(1,147,561)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <u>Deposits</u>	234,077	234,077	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 413,178	\$ 503,608	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,336,200	\$ 1,426,630	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 14,438	\$ 14,438	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	250,000	250,000	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	<u>See Attached Schedule 17-A</u>	1,061,876	1,061,877	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 1,326,314	\$ 1,326,315	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,326,314	\$ 1,326,315	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 9,886	\$ 100,315	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,336,200	\$ 1,426,630	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ (189,301)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ (189,301)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>2,088,579</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,889,392)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 199,187</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 9,886</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number BALMORAL HOME

# 0039966

Report Period Beginning: 11/01/99

Ending: 10/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 6,509,788	1
2	Discounts and Allowances for all Levels	(120,979)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 6,388,809	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	263,476	6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 263,476	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	35	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 35	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	11,179	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 11,179	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Schedule 19A	148,129	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 148,129	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 6,811,628	30

2

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	913,769	31
32	Health Care	1,363,359	32
33	General Administration	746,952	33
	<b>B. Capital Expense</b>		
34	Ownership	1,577,984	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers	3,731	35
36	Provider Participation Fee	117,254	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 4,723,049	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	2,088,579	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 2,088,579	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,088	2,088	\$ 54,109	\$ 25.91	1
2	Assistant Director of Nursing	130	130	1,957	15.05	2
3	Registered Nurses	22,371	23,935	463,101	19.35	3
4	Licensed Practical Nurses	5,528	5,768	88,186	15.29	4
5	Nurse Aides & Orderlies	58,193	60,424	523,986	8.67	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,506	2,564	34,467	13.44	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,932	2,182	21,659	9.93	9
10	Activity Assistants	6,749	7,097	47,389	6.68	10
11	Social Service Workers	7,215	7,561	66,762	8.83	11
12	Dietician					12
13	Food Service Supervisor	2,479	2,508	93,942	37.46	13
14	Head Cook					14
15	Cook Helpers/Assistants	16,235	16,922	113,645	6.72	15
16	Dishwashers					16
17	Maintenance Workers	4,450	4,479	58,374	13.03	17
18	Housekeepers	14,006	14,898	110,925	7.45	18
19	Laundry	6,633	7,115	56,447	7.93	19
20	Administrator	728	728	116,805	160.45	20
21	Assistant Administrator	657	657	36,340	55.31	21
22	Other Administrative	416	416	20,000	48.08	22
23	Office Manager					23
24	Clerical	5,755	6,144	113,188	18.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,971	2,211	24,560	11.11	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,042	167,827	\$ 2,045,842 *	\$ 12.19	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 6,710	L1, Col 3	35
36	Medical Director				36
37	Medical Records Consultant	Monthly	3,032	L10, Col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	27	1,254	L10A, Col 3	40
41	Occupational Therapy Consultant	4	173	L10A, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	2	131	L10A, Col 3	43
44	Activity Consultant				44
45	Social Service Consultant	120	5,523	12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	153	\$ 16,823		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

Facility Name &amp; ID Number BALMORAL HOME

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Marvin Mermelstein	Asst. Administrator	50.00%	\$ 36,340
Barry Taerbaum	Administrator	0.00%	116,805
Henry Mermelstein	Administrative	0.00%	20,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 173,145
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$
C. Professional Services			
Vendor/Payee	Type		Amount
Altschuler, Melvoin & Glasser, LLP	Accounting	\$	5,400
American Express TBS	Accounting		9,785
Checkers, Simon & Rosner, LLP	Accounting		4,200
Kessler, Orlean, Silver & Co.	Accounting		2,050
Klafter and Burke	Legal		16,863
HDSI	Computer Services		4,812
Urban Real Estate Research	Real Estate Appraisal		3,100
Personnel Planners	U/C Consultant		904
Systematic Systems	Billing Consultant		6,054
NHPS	Employee Recruitment		25,548
Brenda Cohen	Collections		1,782
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 80,498
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance	\$		15,477
Unemployment Compensation Insurance			14,332
FICA Taxes			112,383
Employee Health Insurance			19,791
Employee Meals			32,120
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			17,507
Chicago Head Tax			3,112
Union Health & Welfare			22,587
Allocation from Management Co.			13,775
TOTAL (agree to Schedule V, line 22, col.8)			\$ 251,084
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee	\$		
Advertising: Employee Recruitment			17,758
Health Care Worker Background Check (Indicate # of checks performed 221 )			1,550
Yellow Pages Advertising			857
Il Council on Long Term Care			6,074
City of Chicago - License Fees			1,314
IL ASC of Hlthcare Facilities			213
Chicago Sun Times			426
Miscellaneous Dues			375
Less: Public Relations Expense	(		
Non-allowable advertising	(		
Yellow page advertising			(857)
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 27,710
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel	\$		
In-State Travel			
Seminar Expense			2,370
Entertainment Expense	(		
(agree to Sch. V, line 24, col. 8)			\$ 2,370

\* Attach copy of IMRF notifications

**\*\*See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Boiler Repair	Apr-99	\$ 3,765		\$	\$	\$ 628	\$ 1,255	\$ 1,255	\$ 627	\$	\$	\$
2													
3													
4													
5													
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14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 3,765		\$	\$	\$ 628	\$ 1,255	\$ 1,255	\$ 627	\$	\$	\$

Facility Name &amp; ID Number BALMORAL HOME

# 0039966

Report Period Beginning: 11/01/99

Ending: 10/31/00

## XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Illinois Council on Long Term Care \$
- (3) Did the nursing home make political contributions or payments to a political organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 7.5 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 8,857 Line 10
- (7) Have all costs reported on this form been determined using accounting procedure consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 117,254  
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? Yes If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. \$ 32,120 Has any meal income been offset against related costs? No Indicate the amount. \$
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A  
c. What percent of all travel expense relates to transportation of nurses and patients? 0%  
d. Have vehicle usage logs been maintained? Adequate records are maintained.  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ 0
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.